# Massachusetts Department of Public Health HIV/AIDS Bureau

# Guidelines for Service Coordination Collaboratives

# October 2005

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# I.  Introduction

At the beginning of federal funding for HIV/AIDS services, the relative needs of people living with HIV/AIDS were not well understood.  At the same time, the HIV/AIDS service system was responding to the frequent influx of new funding and needed to expand rapidly throughout the Commonwealth.   In order for this expansion to occur in a meaningful way, it was necessary to solicit local input about the service needs of people living with HIV/AIDS and to determine the optimal array of these services in various geographic areas of the state.  To that end, the MDPH HIV/AIDS Bureau supported a system of local HIV care consortia that had primary responsibility for assessing service needs within their respective local areas, prioritizing services for funding, and making resource allocation recommendations within a lead agency/subcontractor contract structure.

The range and interrelationship of the services for people living with HIV/AIDS in Massachusetts are now better understood, while the resource base for these services is reduced.  This shift placed extraordinary pressure on the consortium system to determine how to allocate this shrinking funding base and to make recommendations about reducing or eliminating selected service categories.  In response, the HIV/AIDS Bureau decided to directly fund case management and ancillary support services in its most recent procurement of client services, thereby eliminating the lead agency/subcontractor structure, as well as the system of local consortia that was no longer optimally suited to participate in necessary large-scale planning decisions.

The challenge for community involvement today centers on how to optimize the efficiency and effectiveness of the current service system at a regional level by examining the array of available services, identifying gaps, and determining to what degree referral linkages exist and are coordinated in order to effectively connect consumers to needed programs.  The system of Service Coordination Collaboratives (SCC) now being implemented in Massachusetts is part of the natural evolution of community input from resource planning to service system coordination.  The SCCs are intended to take local input to a new level and provide local stakeholders with a forum to present and address ideas for improving the HIV/AIDS service system as a whole.

# II.  Goals of a Service Coordination Collaborative

## A.  Overview

Each Service Coordination Collaborative (SCC) will strive to meet four broad goals:  (1) improve the referral network of existing resources, (2) assess service system quality, (3) identify and address service gaps, and (4) maximize access to services while minimizing inefficiencies.  Each goal addresses an issue that has emerged over time as a necessary stepping stone on the path to overall service system improvement.  Although the goals are distinct, they are also interconnected in many ways.  The process that the SCC develops to meet one goal may inform the process for meeting other goals.  In addition, the actual results of those processes may provide a foundation for further processes.  There is no prescribed method for meeting these goals, and each SCC will determine for itself how best to proceed.  The only result that is expected from every SCC is that the group's work will ultimately improve the service system in some way for people living with HIV/AIDS.

## B.  Improve Referral Network

An effective and efficient referral network is a critical component of service coordination. Providers of all kinds of social support services must be able to refer clients to each other if the clients are to have access to a seamless continuum of care.  Although most providers who serve people living with HIV/AIDS are able to provide and receive referrals without much difficulty, the referral network is still not perfect, and certainly not as broad as it needs to be.

SCC members are responsible for the coordination of HIV/AIDS Bureau funded client services (including residential services), enhanced medical management services, comprehensive home health services, and correctional health services within the SCC's coordination area. Coordination of services among all of these providers will ultimately improve the referral network for consumers by making it easier for providers to connect with each other.  This coordination effort must include an assessment of consumer service access, as well as development of strategies for making services more accessible when the assessment indicates such a need.

An SCC is also responsible for reaching out to other service providers within the service coordination area and creating linkages that will help facilitate referral and collaboration, which will ultimately help to create a more comprehensive continuum of care for people living with HIV/AIDS.  This includes reaching out to non HIV-specific providers that serve at-risk populations.  Every SCC member is responsible for helping to ensure that these linkages are created.

## C.  Assess Service System Quality

The quality of the service system ultimately determines how well the needs of consumers are being met.  A high quality system will ensure that all consumers have low-threshold access to all necessary and related primary care and support services.  This is the goal of the HIV/AIDS Bureau's work.

On an ongoing basis, each SCC is expected to assess the degree to which the service system within the SCC's coordination area is meeting the needs of consumers living in that area.  This assessment should focus on how the system as a whole is functioning, and should not include assessment of specific provider agencies.  This determination must take into account the kinds of services being provided, including those that are not HIV-specific (e.g., mental health and substance abuse services).  A regional consumer needs assessment may assist with this, as well as a survey of services offered by existing providers in the region, along with the eligibility criteria attached to those services.

## D.  Identify and Address Service Gaps and Barriers

Although the existing HIV/AIDS service system addresses many challenges that people living with HIV/AIDS face, there remain gaps in available services.  The SCC is responsible for designing methods to identify these gaps and developing strategies to address the identified gaps. For example, the SCC may analyze the results of the service system quality assessment to

determine where gaps exist, or they may analyze aggregate service utilization data and compare the results of that analysis with the results of a regional needs assessment. By doing so, the SCC could identify what services consumers think they are missing, see if those results are consistent with the data, and then determine whether or not an actual gap exists. As part of the facilitator's reporting requirements, the facilitator will provide feedback on critical service gaps to the HIV/AIDS Bureau so that the Bureau may consider whether or not redirection of resources is appropriate.

The SCC will also need to consider whether any identified gaps are a result of barriers and, if so, determine how best to overcome those barriers. Barriers may be related to available resources, agency capacity, staff diversity, comprehensiveness of the regional service mix, or any other category that has an effect on how consumers access services. The HIV/AIDS Bureau does not expect an SCC to take full responsibility for overcoming barriers to access. Instead, the Bureau and the SCCs will be partners in this endeavor.

**E.  Maximize Access and Minimize Inefficiencies**

In a time of increasingly constricted resources, maximizing the use of every service dollar is critical. This means that every person in need of HIV/AIDS care and support services must be able to obtain necessary services quickly, easily, and cost-effectively. Increased and improved access to care and support services must be a priority for every SCC. Each SCC will have to determine the most efficient and cost-effective way to maximize access to services, including addressing underutilization of services, without unnecessarily duplicating the services that are available. For example, an SCC may propose adjustments to the service mix in the SCC's coordination area or may choose to address the schedule and location of service availability across agencies. The SCC might also determine that the most efficient means of improving access to services within the region is to develop mechanisms for sharing client information, with appropriate safeguards and releases in place, to expedite the referral process for consumers. Regardless of how the SCC opts to address this issue, the SCC must demonstrate that their efforts will ultimately result in a more efficient service system for their region.

## III.    Products of a Service Coordination Collaborative

The HIV/AIDS Bureau expects each SCC to deliver products that reflect the goals of the SCC. By the beginning of each fiscal year, the SCC must develop a work plan, covering the entire fiscal year, that describes what the SCC will focus on and what the end products will be. The products may be tangible (e.g., a regional referral tool) or intangible (e.g., better communication among members) and may be completed within the fiscal year or over a longer term. The work plan will describe in detail exactly what the group plans to do and how the work of the group will lead to an end product that furthers the goals of the SCC.

An essential component of engaging in goals related work is knowing the degree to which the goals of the group have been achieved. Therefore, in addition to creating actual products, the SCC must determine how it is going to evaluate the effectiveness of its products. The SCC's work plan will include a section that describes what steps the SCC plans to take in order to identify successes, as well as areas that require further attention.

There is no prescribed format for the work plan, but all work plans must include, at a minimum, the following:

- List of service system priorities related to each SCC goal that reflect the needs of the service coordination area, including a discussion of why these priorities have been identified;
- Description of the activities in which the SCC will engage in order to address its stated priorities;
- Timeline;
- Responsible parties;
- Description of end products, how the products will address the SCC's stated priorities, and how the products will be produced and delivered; and
- Proposed evaluation activities to measure the effectiveness of the SCC's work.

## IV.   Operating Procedures

### A.  Purpose

The HIV/AIDS Bureau requires every SCC to have a set of operating procedures, which describe the purpose of the group, how it operates, who may participate, the nature of that participation, and what is expected of members and leaders. These procedures serve as a place to turn for answers when questions arise within the group. This is not meant to be a long or complicated document, or necessarily as formal as bylaws. The operating procedures should maintain enough flexibility to allow the group to move forward and evolve over time while creating a structure that fosters collaboration and productivity.

### B.  Process

It is recommended that each SCC form an operating procedures committee to develop the SCC's operating procedures. The operating procedures committee will then bring its draft to the SCC membership for discussion, revision, and consensus adoption. At least once every two years, the procedures committee should review the operating procedures and make recommendations for amendments, if necessary, to the SCC. The HIV/AIDS Bureau has created sample operating procedures to assist with this process. The sample procedures may also be used as a template for the SCC's own procedures.

### C.  Elements

Operating procedures are often divided into several sections, each of which describes some aspect of the group's operations. An SCC can decide for itself what additional information it wants to include in its operating procedures, but all operating procedures should include, at a minimum, descriptions of the following:

- The SCC's purpose, mission, or other foundational statement;
- Definition of a member;
- The scope of the group's work;
- The roles and responsibilities of the SCC membership;

- The roles and responsibilities of the SCC coordinator/facilitator;
- How information is shared among SCC members and how members conduct themselves;
- A description of the SCC's committees, if applicable;
- How often the group meets and how minutes are shared;
- A statement about confidentiality; and
- A mechanism for amending the operating procedures.

## V.    SCC Membership

### A.  Required Members

1.  <u>HIV/AIDS Bureau Funded Providers</u>
The MDPH HIV/AIDS Bureau requires that all agencies receiving funding under contract with the Bureau for client services (including residential services), enhanced medical management, comprehensive home health, and correctional health be active members of their SCC.  Being an active member of the SCC includes having appropriate staff attend and participate in SCC meetings.

2.  <u>Consumers</u>
Consumers make up another group that is critical to the SCC process.  For purposes of SCC membership, a consumer is any individual who identifies within the SCC as a person living with HIV/AIDS, or the parent or guardian of an individual under age 21 living with HIV/AIDS.  Consumers will be full, equal members of the SCC and will have the same opportunities for input that are afforded to all members.  Active consumer participation is the only way to ensure that the SCC's discussions are realistic and well informed.

The HIV/AIDS Bureau requires that consumers account for at least 25% of the SCC membership.  If an SCC is unable to achieve the required 25% consumer representation, the SCC must make every effort to come as close as possible to the desired percentage, including submission of a written plan that explains the SCC's outreach and recruitment efforts.  This plan must be submitted to both the SCC's contract manager and the HIV/AIDS Bureau Consumer Office.

### B.  Recommended Members and Other Participants

Because people living with HIV also receive services from providers whose services are not necessarily HIV-specific, these providers are encouraged to participate in their local SCC in any number of ways.  Human service providers tend to serve populations that are at risk for HIV infection and, as a result, these providers often provide services to people who are HIV-positive.  These providers therefore represent critical linkages for referral and collaboration within an area.

Some providers may have a greater stake in the SCC's work and will want to be full members of the SCC.  Others may participate in less formal ways and attend meetings periodically.  Still others will serve primarily as sources of information and may be invited to speak at a particular meeting about a specific, designated topic.  However these providers choose to participate, their input will be an important element of the SCC's work toward meeting its goals.

Examples of these other kinds of agencies or organizations include:

- Substance abuse treatment programs/detoxification centers
- Mental health providers
- HIV Prevention and education providers
- Counseling and testing sites
- Population-specific community-based organizations
- GLBT social and support organizations
- Jails
- Independent living centers
- Legal services
- Hospitals
- Community health centers/Ryan White Title III providers
- Ryan White Title IV/MassCARE providers
- STD clinics
- Representatives from state and local government
- Housing programs
- Faith-based organizations
- Visiting Nurse Associations
- Homeless shelters
- Emergency services providers
- Hospice
- Infectious disease specialists
- Workforce development specialists
- Literacy advocates

## VI. Responsibilities of the SCC Contract Holder

### A. Coordination

<u>1. Meetings</u>
Each SCC must have a regular meeting schedule so that members and other participants know when to attend. The HIV/AIDS Bureau requires that each SCC meet at least four times per year. Beyond that, the SCC may meet as often as it chooses, depending on its needs. For example, the SCC may choose to meet on the second Tuesday of every month, or the third Wednesday every other month, or whatever works best for the majority of members. The meeting schedule must be made available to all members.

The contract holder is responsible for ensuring that:
- Consumers are recruited to be members;
- Members are informed about upcoming meetings;
- Outside providers are invited to meetings, as appropriate;
- An accessible meeting space is secured; and
- Food is provided at meetings, as appropriate.

2. Committees

An SCC may choose to create committees for the purpose of addressing particular issues. If the SCC does so, the purpose, nature, and membership of the committee must be made known to the membership and described in the SCC's operating procedures.

3. Meeting Minutes

The minutes serve as the official written record of a meeting. The SCC must record minutes for every meeting so that they may be referred to in the future when information from a past meeting becomes important. The minutes must then be distributed to all SCC members and be approved (with corrections, if necessary) at the next SCC meeting. In addition, each SCC is required to submit a copy of the minutes from each meeting to the SCC's contract manager once the minutes have been approved by the SCC.

4. Confidentiality

SCC meetings are open and public meetings at which any number of individuals, whether members or visitors, may be present. Therefore, it is critical that meeting attendees utilize the utmost discretion when discussing information of a sensitive or personal nature. Such information includes, but is not limited to, information about a person's health or HIV status, relationship with any provider agency, employment situation, or involvement in a survey or focus group. The SCC should have a discussion about how best to manage confidentiality within the group, including how to note consumer attendance in the meeting minutes, and then codify the results of that discussion in the SCC's operating procedures.

To ensure the full integration of people living with HIV into SCC processes and discussions, consumers are strongly encouraged to identify as such within the group in order to ensure that all discussions held by the SCC are publicly and adequately informed by consumer input. Although some consumers may not feel comfortable disclosing their status in a public meeting, and cannot be compelled to do so, it is essential that meeting participants know when consumer input is being provided. To protect the confidentiality of these consumers outside of the group, consumers are encouraged not to disclose their full name to anyone other than the meeting facilitator. Any questions that arise around confidentiality should be directed to the SCC's contract manager or to the HIV/AIDS Bureau Consumer Office.

## B. Facilitation

The agency holding the SCC contract is being funded to plan, coordinate, and facilitate SCC meetings. The HIV/AIDS Bureau expects that this facilitation will be skilled, informed, and participatory. Group leaders will, of course, emerge from the membership, and this should be encouraged. However, it is the primary responsibility of the contract holder to run the meetings and ensure that the group's goals are met and the end products are delivered. It is also the responsibility of the facilitator to ensure that every meeting be a consensus process. Each decision reached by the SCC membership should be a consensus decision that reflects the general agreement of the group. See Appendix 1 for tips on consensus building.

## C. Orientation

It is recommended that funded SCC coordinators, along with other SCC members, provide an orientation for all new SCC members. Although all SCC members will be new in the first year

of the SCC system, it is expected that new members will continue to be identified over the life of the SCC.  Without a complete understanding of the SCC's function and purpose, a member cannot fully and effectively participate in the process.  Therefore, it is incumbent upon the veteran members to orient the new members.

One way to help new members become acquainted with the SCC is to provide them with an orientation packet.  Such a packet might include the following:

- The SCC's meeting schedule;
- The SCC's operating procedures;
- A list of SCC member agencies;
- The SCC's work plan;
- Meeting minutes from the past two meetings;
- The contract holder's contact information;
- A copy of the Guidelines for Service Coordination Collaboratives; and
- Any other information that might be relevant.

### D.  Reporting

At least two times per year, the facilitator will be responsible for submitting a report that describes the SCC's progress on its work plan activities.  The HIV/AIDS Bureau will provide a format for this report.  By the end of each fiscal year, the final products (or an update or description thereof) will be due.  The priorities, activities, and products will necessarily vary according to the needs of the region represented by the SCC, but will all be related in some way to the four goals of the SCC system.  In addition, the facilitator is responsible for maintaining ongoing communication with the Bureau and acting as a liaison between the Bureau and the SCC.

### E.  Appropriate Expenditures

Expenditures will be limited to those that directly support the SCC process.  Appropriate expenditures related to coordination of the SCC and its meetings include the following:

- SCC coordinator position;
- Stipends for consumers attending SCC meetings;
- Reimbursement for transportation and child care for consumers attending SCC meetings;
- Language interpretation;
- Food and other refreshments for SCC meetings;
- Materials and supplies;
- Photocopying;
- Postage; and
- Advertising and announcements.

## VII.   Technical Assistance

Each SCC is a partnership between the HIV/AIDS Bureau and the community.  Although the focus of the SCC system is on community organization and leadership, there will be times when the SCC will require the assistance of the HIV/AIDS Bureau.  When the SCC, or the SCC facilitator, feels that technical assistance is required, the facilitator should contact the SCC's contract manager.  The contract manager will then determine how best to assist the SCC.

# Appendix 1:  Consensus Building

## What is consensus?

Consensus is a process for group decision making. It is a method by which an entire group of people can come to an agreement. The input and ideas of all participants are gathered and synthesized to arrive at a final decision acceptable to all. Through consensus, we are not only working to achieve better solutions, but also to promote the growth of community and trust.

## Consensus vs. voting

Voting is a means by which we choose one alternative from several. Consensus, on the other hand, is a process of synthesizing many diverse elements together.

Voting is a win or lose model, in which people are more often concerned with the numbers it takes to "win" than with the issue itself. Voting does not take into account individual feelings or needs. In essence, it is a quantitative, rather than qualitative, method of decision making.

With consensus people can and should work through differences and reach a mutually satisfactory position. It is possible for one person's insights or strongly held beliefs to sway the whole group. No ideas are lost, each member's input is valued as part of the solution.

## What does consensus mean?

Consensus does not mean that everyone thinks that the decision made is necessarily the best one possible, or even that they are sure it will work. What it does mean is that in coming to that decision, no one felt that her/his position on the matter was misunderstood or that it wasn't given a proper hearing. Hopefully, everyone will think it is the best decision.

Consensus takes more time and member skill, but uses lots of resources before a decision is made, creates commitment to the decision and often facilitates creative decision. It gives everyone some experience with new processes of interaction and conflict resolution, which is basic but important skill-building. For consensus to be a positive experience, it is best if the group has (1) common values, (2) some skill in group process and conflict resolution, or a commitment to let these be facilitated, (3) commitment and responsibility to the group by its members, and (4) sufficient time for everyone to participate in the process.

## Forming the consensus proposals

During discussion a proposal for resolution is put forward. It is amended and modified through more discussion, or withdrawn if it seems to be a dead end. During this discussion period it is important to articulate differences clearly. It is the responsibility of those who are having trouble with a proposal to put forth alternative suggestions.

The fundamental right of consensus is for all people to be able to express themselves in their own words and of their own will. The fundamental responsibility of consensus is to assure others of their right to speak and be heard. Coercion and trade-offs are replaced with creative alternatives, and compromise with synthesis.

When a proposal seems to be well understood by everyone, and there are no new changes asked for, the facilitator(s) can ask if there are any objections or reservations to it. If there are no objections, there can

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be a call for consensus. If there are still no objections, then after a moment of silence you have your decision. Once consensus does appear to have been reached, it really helps to have someone repeat the decision to the group so everyone is clear on what has been decided.

**Difficulties in reaching consensus**

If a decision has been reached, or is on the verge of being reached, that you cannot support, there are several ways to express your objections:

Non-support: "I don't see the need for this, but I'll go along."

Reservations: "I think this may be a mistake, but I can live with it."

Standing aside: "I personally can't do this, but I won't stop others from doing it."

Blocking: "I cannot support this or allow the group to support this."

Withdrawing from the group: Obviously, if many people express non-support or reservations or stand aside or leave the group, it may not be a viable decision even if no one directly blocks it. This is what is known as a "lukewarm" consensus.

If consensus is blocked and no new consensus can be reached, the group stays with whatever the previous decision was on the subject, or does nothing if that is applicable. Major philosophical or moral questions that will come up with each affinity group will have to be worked through as soon as the group forms.

**Roles in a consensus meeting**

There are several roles which, if filled, can help consensus decision making run smoothly. The facilitator(s) aids the group in defining decisions that need to be made, helps them through the stages of reaching an agreement, keeps the meeting moving, focuses discussion to the point at-hand, makes sure everyone has the opportunity to participate, and formulates and tests to see if consensus has been reached. Facilitators help to direct the process of the meeting, not its content. They never make decisions for the group. If a facilitator feels too emotionally involved in an issue or discussion and cannot remain neutral in behavior, if not in attitude, then s/he should ask someone to take over the task of facilitation for that agenda item.

A recorder can take notes on the meeting, especially of decisions made and means of implementation and a time keeper keeps things going on schedule so that each agenda item can be covered in the time allotted for it (if discussion runs over the time for an item, the group may or may not decide to contract for more time to finish up).

Even though individuals take on these roles, all participants in a meeting should be aware of and involved in the issues, process, and feelings of the group, and should share their individual expertise in helping the group run smoothly and reach a decision. This is especially true when it comes to finding compromise agreements to seemingly contradictory positions.

Adapted from ACT UP, *Consensus Decision Making*, Retrieved October 18, 2005, from http://www.actupny.org/documents/CDdocuments/Consensus.html.